Take a proactive role to address RACs and the increased use of third-party payer validation organizations

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For fiscal year 2007, Recovery Audit Contractors (RAC) identified and corrected $371 million dollars of Medicare improper payments. Previously written articles published throughout the last year have discussed the magnitude of the monies the RAC recouped. RACs collected the most overpayments from inpatient hospitals; they collected $312.8 million dollars in overpayments from inpatient hospitals and skilled nursing facilities.

Almost half of the improper payments resulted from incorrect coding. According to the RAC status document report, most improper payments occurred when providers submitted claims that did not comply with Medicare's coding or medical necessity policies and rules. 42% percent of the identified overpayments to providers occurred on the basis of incorrectly coded records.

Identify incorrectly coded records

The coders must correctly document each clinical encounter using a heightened awareness of clinical medicine, an ability to interpret the medical record, and knowledge of the official coding guidelines and policies. However, the subjective nature of official coding guidelines may cause experts to disagree on the "correct" way to assign principal and secondary diagnoses for a particular patient. In reality, DRG accuracy reviews are nothing more than "recoupment" audits for the third-party payers. RACs often disregard proper application of coding rules and guidelines.

Despite the coder's best efforts to review records and account for medical necessity, some third-party payers take question the assignment and sequencing of ICD-9 codes. Third-party payers increasingly use organizations similar to RACs, because these organizations may help recoup money from the hospitals by conducting post payment reviews on selected DRGS. Organizations conduct these investigations under the premise of identifying incorrect codes that turn result in inaccurate DRG assignment and improper reimbursement.

Beware of unnecessary recoupment audits

Consider the following case study that illustrates an unnecessary recoupment audit. A physician admitted a 68-year-old patient to the hospital from the emergency room (ER) with a provisional diagnosis of "altered mental status, rule out sepsis." The patient's vital signs in the ER read as follows: temperature 100° F, respiratory rate of 20, heart rate of 76, and blood pressure of 220/170. The patient's white blood count showed a slight elevation at 12, with a low-grade shift of bands. This reading suggested a possible infection. The patient received one dose of IV Rocephin in the ER, and staff members transferred the patient to the hospital floor.

The attending physician evaluated the patient within an hour of hospitalization and continued the IV antibiotics. During the course of the inpatient stay, patient received IV blood pressure medications for the dangerous rise in blood pressure. The patient also received two additional doses of IV antibiotics and experienced a drop in blood pressure to more normal levels. The patient then returned to baseline dementia. The hospital physician transferred the patient back to the nursing home where he or she resides on day three of the hospitalization. Upon discharge, the patient continued his or her pre-hospitalization regimen of medications.

Because the physician did not include many progress notes in a timely manner, the coder assigned the following codes based on documentation in the discharge summary:

- 038.9—Sepsis
- 403.00—Hypertensive emergency with chronic renal failure
- 294.8—Dementia
- 244.9—Hypothyroidism

- 272.4—Hypercholesteremia

These codes group to DRG 872 (septicemia without mechanical ventilation 96+ hours without MCC, relative weight 1.3783). The hospital's third-party audit firm reviewed the record six months after the hospital received payment for the patient encounter. The audit firm most likely chose the record for post-payment review due to the high relative weight of the case, the relatively short stay in the hospital, and the high reimbursement that the hospital received. The outside audit reviewer wished to change the assigned codes, and he or she forwarded this case to the hospital correspondence department with the following changes:

- 401.9—Hypertension
- 585.9—Chronic renal failure
- 294.8—Dementia
- 244.9—Hypothyroidism
- 272.4—Hypercholesteremia

The codes group to DRG 305 (hypertension without MCC, relative weight 0.5942).The auditor argued that given the patient's clinical presentation and the physician's management of the patient, the coder should not have reported a code for sepsis and instead should have reported the following:

- 403.00—Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified or unspecified
- 585.9—Chronic Renal Failure
- 294.8—Dementia
- 272.4—Hypercholesteremia

These codes group to DRG 684 (renal failure without CC/MCC, relative weight 0.9835). A quick glance at the proposed code sets indicates the reviewer may have disregarded the coding guidelines or that he or she simply did not know how to code hypertension with chronic renal failure. Because third-party audit companies receive a portion of the monies recouped by the client insurance company, they have an interest in identifying incorrect doing. Many HIM professionals know that the third-party audit companies receive a bounty similar to the RAC for recouping monies for their client insurance company. Professionals also know that the reviewer may feel swayed towards misinterpretating coding rules and guidelines when deciding to "resequence" the code assignments that the coder initially submitted in an attempt to earn a commission on the recoupments themselves.

Understand the coder's role in RAC audits

If a coder is uncertain as to whether he or she should write an appeals letter that clearly explains how he or she arrived at the principal and/or secondary diagnoses, the coder should rethink the coding sequence. In this case, the coder should inquire whether the clinical entity currently under consideration for code assignment truly does not meet the clinical definition of principal or secondary diagnosis.

Coders may request more definitive medical record documentation from the physician to provide for complete and accurate code assignment. Follow the advice of *Coding Clinic* to seek clarification and query the physician when uncertain if the principal diagnosis is unclear. The coder can do his or her part to be proactive in not contributing to the feeding frenzy and gold rush of the third-party record-auditing firms.

Decrease coding isolation in the revenue cycle

Coders may assist in handling insurance denials and DRG downgrades by participating in denial management revenue cycle initiatives. They may help their facility by becoming familiar with the audit process, ensuring more vigilant documentation from physicians, and always attempting to code correctly. Additionally, coders can assist in the denials and appeals process for claims that have been identified as allegedly being "coded inaccurately" and subject to potential money recoupements. They may also assist in the appeals and denials process for claims that an audit may identify as inaccurately coded. All of these steps may reduce revenue leaks for the hospital.

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